Appendix A

Survey of Facilities in Wave 1 Catchment Areas

Note: This 2-page survey was FAXED to all NFs in the areas sampled for Wave 1.

Quality of Life Project Facility Questionnaire: Page 1

We need background information on all nursing homes in the region. Please take a few moments to answer the questions below. Feel free to estimate, when unsure. When completed please

FAX both pages to 612-624-5434

Facility name:
Address:
City, State:
Facility Administrator:

Q1 How many residents are currently in your facility? _____

Q2 How many residents do you have in private rooms? _____ *A private room is defined as a room that will not have another resident in it, even if it has two beds. (Do not count a room that temporarily has just one resident.)*

Q3 How many residents are in rooms with 3 or more beds? _____

Q4 What percent of residents would you estimate are cognitively impaired? *Cognitively impaired refers to residents who would ordinarily count as moderately or severely impaired on Section B of the MDS.*

□90%+ □80% □70% □60% □50% □40% □30% □20% □10% or fewer

Q5 How many units do you have in your nursing home? _____ *A unit is any part of the facility that is designated as a distinct care area regardless of whether it has its own nursing station.*

Q6 Do you have any of the following designated special units:

a. Dementia Special Care Units (SCUs)..... □ Yes □ No If yes, how many: _____
b. Hospice/terminal care..... □ Yes □ No If yes, how many: _____
c. Rehabilitation/short stay..... □ Yes □ No If yes, how many: _____
d. Other specially designated units..... □ Yes □ No If yes, how many: _____

Please identify the types for any other designated units that you have: _____

_____

Q7 Do you have a Continuous Quality Improvement or Total Quality Management program?..... □ Yes □No

Q8 In your opinion, does your CQI process explicitly include quality of life?..... □ Yes □No

Q9 Do you have a clinical information system that utilizes information based on the MDS? ..... □ Yes □No

Q10 Do you have any system to get satisfaction information from residents or family members?..... □ Yes □No

Q11 Was the information or consumer feedback system that you use developed by any of the following:

a. □ AHCA or its state affiliate b. □ AAHSA or its state affiliate c. □ own corporation

d. □ not applicable□no system e. □ other - SPECIFY _____

Q12 Has any nursing home in your state, including your own, made a dramatic positive difference in the quality of life of its residents. For example, is there a facility where the very nature of living in a nursing home has changed?

□ Yes □ No If yes, name and location _____

Briefly explain why you think this facility is so outstanding in quality of life:

Be sure to complete next page

Please fax back both pages to (612) 624-5434. Thank you!

Quality of Life Project Facility Questionnaire: Page 2

FAX to 612-624-5434

Q13 In your opinion, has your nursing home made strong progress in improving residents= quality of life by making any of the following changes?

a. use of existing physical space ..... □ Yes □ No
b. renovations of some or all of building ... □ Yes □ No
c. new construction ..... □ Yes □ No
d. furnishings or fixtures ..... □ Yes □ No
e. equipment or appliances ..... □ Yes □ No
f. staff roles ..... □ Yes □ No
g. staff scheduling & deployment ..... □ Yes □ No
h. programs for residents ..... □ Yes □ No
i. policies & procedures ..... □ Yes □ No
j. philosophy of care ..... □ Yes □ No
k. other - describe in Question 15 below.

Q14 Name of person completing form: _____

Title/Position _____ Phone _____

Q15 If you answered "yes" in Q13, please use the rest of the page to provide specifics about your approach to improving quality of life and how it has worked. (Attach pages or mail additional materials, if applicable.)

Please Fax both pages to 612-624-5434

Thank you for completing this questionnaire!